UNIVERSITY OF LIVERPOOL | SCHOOL OF MEDICINE

Blackpool Teaching Hospitals
NHS Foundation Trust
NHS

Trinity Hospice
Compassion and care

Palliative Care

YEAR 4 MEDICAL STUDENT

COMMUNICATIONS SKILLS HANDBOOK

ACADEMIC YEAR
September 2019 to June 2020

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Communication Skills Handout – 4th Year Medical Students

Contents

Page

Communication Skill Theory

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Contents

Page

Guidance for particular situations

This handout contains some background information about communication skills.

It is NOT a comprehensive textbook or an instruction manual on how to do things, but is offered as an aide memoire to help embed learning.

Core Learning Objectives of the Three Day Course are:

LO1: To describe the impact of facilitating and blocking behaviours on communication in Palliative and End of Life Care.

LO2: To discuss the influencing factors and consequences of communication in Palliative and End of Life Care.

LO3: To demonstrate the ability to elicit worries and concerns of patients and relatives across Physical, psychological, Social and Spiritual domains.

LO4: To demonstrate the ability to deal with difficult questions and situations.

LO5: To demonstrate the ability to deliver bad news sensitively, and be able to tailor this to the individual needs of the patient or carer.

LO6: To demonstrate the ability to respond appropriately to specific emotions such as distress and anger in Palliative and End of Life Care.

The aim of the sessions is to make them lively and relevant to clinical practice. However some of the topics we are likely to cover in the two days are challenging ones that even experienced healthcare professionals struggle with. It is essential that each student is professional and looks after themselves as well as their colleagues. Please highlight to the facilitator if a scenario (either their own or one of their colleagues) is "too close to home".

Strategies around specific scenarios which will be covered even if they are not role played by the students:

- Using difficult words such as cancer, death
- Responding to strong emotions
- Discussing Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)
- Dealing with collusion
- Dealing with denial.

The course will be delivered by an experienced healthcare professional working in palliative care (with experience in delivering communication skills training) with an actor trained in delivering communication skills training (including safe, constructive feedback by the actor in role).

Ground Rules for the Three days:

Attendance at all THREE days is compulsory

We will cover the following key areas and will be negotiated for each group:

- **Participation** – all students will be expected to attend the two days in full. Missing either day will mean potentially having to redo both days with another group in the future. All students will be expected to actively participate and will undertake one role play during the two days.
- **Confidentiality** – what can be taken out of the room and what needs to remain confidential to the sessions?
- **Respect** – it is expected that all involved will show respect for each other, the facilitator and actor.
- **Time Keeping –** days will start on time and the facilitator will endeavour to keep to time. Students are expected to arrive and be ready to start on time for all the sessions.
- **Non-Judgemental Feedback** – feedback from the group and from the facilitator will be constructive, positively framed and non-judgmental based on observed practice and given with observed evidence from the role play observed.
- **Don't make it 'close to home'** – when setting up the role plays we will ask if the details relate to/ remind someone of anything that is or has gone on in someone's life; we try and avoid this to avoid someone being upset by an example (which would affect learning/performance)

- **Mobile phones** – to be switched off (or on silent) and only used during designated breaks.

In addition there are specific givens for each role played scenario. The aim of each scenario is that it is realistic but not real. The aim is to set up a situation that may happen or may have happened in the past which enables the individual student to practice their communication skills in a safe and supportive environment.

Role Play Regulations
All students will role play themselves as an experienced medical student or FY1 doctor with an actor assuming the role of the patient/relative or colleague in a scenario of their choosing.

The student can request time out if they feel stuck or unsure of which direction to take the role play.

The facilitator will stop the scenario if they feel the student needs help or there is a learning point to bring out.

The group will be actively observing the role play and will be expected to support their colleague by providing non-judgemental feedback and feedback as requested by the facilitator covering areas:

- **Key facilitative skills** demonstrated by the student such as:
  - use of open questions,
  - effective use of non-verbal communication
  - acknowledging patient's agenda/concerns
  - clarifying and exploring statements made by the actor
  - how appropriate empathy is shown
  - demonstrating active and engaged listening.
- **Verbal cues** given by the actor.
- **Non-verbal cues** given by the actor.

Introduction

- The consultation is the bedrock of all medical practice. **Being an effective doctor requires excellent communication skills within that consultation**.
- We all have our preferred ways of communicating and in most instances these will be good enough to ensure shared understanding between doctor and patient and/or relative.
- In addition **doctors must have good interpersonal skills to enable effective team working**.
    - All doctors need to be able to communicate effectively and accurately with clinical colleagues, **so spending time learning about communication styles and frameworks is essential for all doctors and medical students to enable them to practice effectively and safely.**
- The challenge is that **we tend to assume we are communicating well most of the tim**e when the reality is different:
    - *we all tend to hear what we want to hear and not what is being said;*
    - *we all make assumptions about what people are likely to say;*
    - *often we are planning what we are going to say next rather than listening to what the other person is saying to us;*
    - *we rarely listen for more than two minutes at a time unless we make a conscious effort to do so.*
- Poor communication skills lead to bad outcomes: for patients, their families, for healthcare professionals and for the health service that is trying to ensure the highest standards of care.
- There is considerable evidence that **we can be taught additional skills that we can personalise which enhance our ability to communicate, particularly in challenging situations.**
    - **It is a skill that EVERYONE can learn:** don't have to be a natural good communicator, **BUT IT TAKES PRACTICE!**
    - Communicating well can take a significant amount of time. Communicating badly may take less time initially, but takes a lot longer in the long run and can have long term damaging consequences for both the patient and the doctor!
- Evidence suggests that:
    - the longer a doctor waits before interrupting the patient the more likely s/he is to discover the full reason for attendance NB: *the average time in a GP consultation for a doctor to interrupt a patient is around 20 seconds;*
    - communication that is patient-centred ie where the patient is enabled to ask questions and invited to summarise what has been heard is associated with improved health outcomes.
    - using 'cue-based' consultations models (see below) – with certain facilitation techniques (eg. using open or open directive questions leads to patient disclosure) is associated with better outcomes for both patient and healthcare professional

Why Such an Emphasis on Communication Skills?

"If you can't communicate, it doesn't matter how much you know"

It is what patients & families want from us

- Surveys and research into patient preferences and what is important to them show
  - **"effective communication"** between patients, families and healthcare professionals (HCP) is a high priority for those with advanced life-threatening illness
  - **most want all information (bad & good)** even when prognosis is short, to help them make important decisions with their time left
  - patients want to be **included in the conversation**, **involved in decision making**, **asked about themselves** so HCP can get to know them
  - they want HCPs to treat them with **humanity, dignity and respect** whatever their circumstances
  - they want to be treated by HCPs who are **empathetic and sensitive to emotions**, **who listen to them**
  - they want HCPs to give them **honest, straightforward understandable advice** about their illness/treatment

Good and bad communication is linked to outcomes

- Communication is linked to measurable outcomes

Patient Outcomes

- **Good communication** is linked with shorter hospital stay, quicker pain control, better medication compliance, shorter GP, surgical and oncology consultations, fewer follow up appointments, fewer visits to GP surgery, patient satisfaction, better emotional health, better symptom resolution, better measures of function and physiology (eg BP)
- **Bad communication** is linked with patient dissatisfaction, psychological distress, poorer quality of life, poorer analgesia, poorer compliance, more complaints & litigation

Complaints: poor communication has been cited as being significant in complaints for decades: some reports have poor communication as the significant reason for the complaint; others show that poor communication is part of a significant number of complaints made for other reasons

One analysis of NHS complaints showed the following key issues:

(Beckman, Markaris, Suchman et al, 1994)

- Patient felt deserted
- Patient's felt problems devalued
- information was delivered poorly
- there was a failing to understand patients' perspectives

Parliamentary and health ombudsman, 2011

"Issues of confidentiality, insensitive or inappropriate language, use of jargon and a failure to take account of patients' own expertise in their condition feature frequently in complaints"

Impact of life threatening illness

"…anxiety and depression were sometimes exacerbated by what they considered to be thoughtless or even callous attitudes of the health professionals who treat them." (National Cancer Alliance 1996)

"It's as if you've been to court and you're waiting for the jury to come back and find out whether you've got a death penalty or not…. They decide how long you're going to live for basically…" NSF assessment (2001)

Issues Raised in Cancer/Palliative/End of Life Care

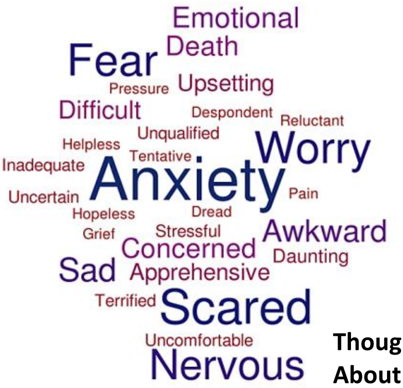
- Prognosis
- Treatment Issues
- Side effects
- Mood
- Body Image Relationships
- Sexuality
- Coping with change
- Being open with others
- Causation
- Control

Good and bad communication is linked to outcomes

- Communication is linked to measurable outcomes

  Healthcare Professional Outcomes

  - **Good communication** is linked, better job satisfaction, less work place stress
  - **Bad communication due to insufficient training** is linked to psychological distress and morbidity, lack of job satisfaction, workplace stress, emotional burnout



Thought cloud by 2nd year medical students at Liverpool University
About dealing with difficult conversations around end of life care

The importance of good communication is recognised in reports, guidance & policy

- The importance of good, effective communication has been enshrined in various reported, guidance and policies to achieve better quality of care, especially for end of life care
  - The National Cancer Plan (2000)
  - National Service Framework Assessment (2001)
  - NICE Guidance On Cancer Services (2004)
  - National Audit Office (2005)
  - Healthcare Commission (2007)
  - End Of Life Care Strategy (2008)
  - Francis Report (Mid Staffordshire. NHS Foundation Trust. Public Inquiry)
  - One Chance to Get it Right (LACDP 2014)
  - Dying Without Dignity (Parliamentary and Health Service Ombudsman 2015)
  - Ambitions for Palliative and End of Life Care (Palliative and End of Life Care Partnership 2015)
  - Care of Dying Adults in the Last Days of Life (NICE 2015)
- Communication skill training research evidences that the consultation skills for patient-centred consultations can be both acquired and retained.
- We cannot rely on *"learning from experience"* because research shows that communication skill is not something that improves with experience alone, it is a skillset that needs to be taught and assimilated into practice
  - *"What we learn from history it that people don't learn from history."* (George Bernard Shaw)

Examples of barriers to effective communication: Healthcare professional (HCP)

NB: Person = patient or relative

HCP FEARS

- **of producing strong emotions:** (*eg anger, tears, screaming*) that you can't deal with
- **of 'damaging' the person:** doing harm, saying wrong thing, adding to persons problems, making it worse for them
- **of upsetting person:** similar to above two
- **of saying wrong thing:** especially if you aren't sure yourself, information complex or difficult to explain OR you have strong personal belief about how the situation should be approached
- **of being asked difficult/unanswerable question:** puts you on the spot when you don't know *("Am I dying, Dr?")*, puts you into possible conflict with other (*"This should have been found earlier shouldn't it?"; "A mistake has been made hasn't it?"*), or has no answer (*"What have my children ever done to deserve this?*)
- **of person rejecting your advice:** refusing to accept your opinion, refusing possible life saving treatment
- **of taking up too much time:** in busy clinic/situation don't want to open 'can of worms' that could lead to having to deal with strong emotion/difficult conversation that would take time

HCP BELIEFS

- **'Not my role':** that should be done by GP/specialist/ someone who is more experienced than you
- **'No point in talking about fears':** you can't fix it anyway, there's no answer, allowing patient to talk may distress them, could upset them, raises expectation/hope something can be done
- **'Emotional problems are inevitable':** what you would expect in circumstances, 'normal' in circumstances, better to just accept them, since can't do anything, same as for *'no point in talking about fears'* above
- **'Person won't be able to cope':** important for HCP to protect person and not to make things worse
- **'It will take too much time to listen/deal with it':** to listen, aknowledge emotions, deal with any emotional fall out, giev information, advice etc

HCP LACK OF SKILLS

- **Don't know how to deal with cues:** recognise, acknowledge and assess understanding and perceptions
- **Can't integrate different parts of the consultation:** never been taught the structure to follow or how to do the elements of establishing rapport ("introduction"), assessing knowledge & concerns ("gathering & exploring") before giving information ("giving & explaining") before closing; unable to move through the medical, psychological, social & spiritual agendas
- **Can't handle specific situations:** no training in dealing with the angry or tearful or the garrulous person, or deliveriung significant news (inclduing bad news), handling a complaint etc
- **Can't move into and out of dealing with feelings/emotions safely** (the person or even your own)

CONSTRAINTS OF WORKING ENVIRONMENT ON HCP

- **Not enough space or privacy:** causing issues of dignity and confidentiality
- **Interruptions:** bleep, pagers, phones, other staff
- **Lack of time:** to adequately deal with diffucult conversations, or unexpected events
- **Others present:** eg. relatives, students, colleagues etc no space away from other who may inhibit conversation
- **Others not available:** conversation inhibited by those who should be there eg relatives, colleagues
- **No support or referral pathway:** eg you have no where you can refer the person to for more help
- **No support for you:** no support from colleagues, family etc if you are finding situations with person difficult
- **Team conflict:** you emotional energies are taken up with suporting colleagues or watching you own back

HCP BLOCKING BEHAVIOURS

- Communication skills training research/theory suggests there are two parts to what we communicate a) a 'factual content' component (ie. What we 'think' about the facts as we see them) and b) the 'emotional' component (how we 'feel' about what we 'think'). With illness, the emotional component is often 'concern & worries'. **If the HCP can pick up on BOTH what the person 'thinks' and the 'concern & worries' the person 'feels', it leads to better disclosure and a better outcome.**
- We can disclose the emotional distress directly or indirectly by giving cues (see below). Research shows it is important to identify and acknowledge these 'concern & worries' to get a better outcome. Furthermore, **if HCPs ignore cues (switch away or block/inhibit them), a person will give up and stop trying to give us key messages that they need to tell us**.
- On average, a person will try to give cues into key worries 3-5 times per consultation. However, the very first cue at the consultation start seems to be the most important and if missed, the number of cues a person gives in a consultation is reduced regardless of HCP behaviour or success at dealing with subsequent cues.

HCPs can 'block' disclosure of worries and concerns... (Ford et al 1996; Butow et al 2006)

  - Questions asked are predominantly bio-medical.
  - Very few open questions are used
  - Clinicians respond to 70% of [non-emotional] questions but less than 30% emotional cues

OBVIOUS: FULL BLOCKING

- **Moving away from the content and emotion: OR**
- **changing subject / personal chit chat: OR**
- **refusing to engage/inhibiting:**

Patient: "I am worried about what I was told at hospital."
HCP: *"So how have you been physically."* OR
"So how is your husband at present." OR
"How did you son get on with his exams?" OR
"I'm sorry…but I can't deal with that today" OR
"I'm sorry it is inappropriate for me to deal with that,"

MORE SUBTLE: DISTANCING STRATEGIES "switching" focus / time / person

- **Switching focus:**
  HCP stays with part of content but moves away from the emotional part

  Patient: "I was devastated by the news they gave me."
  HCP: *"What symptoms did you have?."*

- **Switching time:**
  HCP stays with part of content but moves time frame – stopping person from expressing how they felt at time of distress (may even focus on 'better' times – eg adding 'normalising' see below)

  Patient: "When it happened I really felt bad."
  HCP: *"So how do you feel now?."*
  "But things are better for you now aren't they?"

- **Switching person:**
  HCP stays with content and even emotion but focussed on someone other than the person

  Patient: "I was so worried that the treatment wasn't working."
  HCP: *"And did you wife think the same thing too?."*

MORE SUBTLE: DISTANCING BEHAVIOURS

- Premature advice / information
- Premature or false reassurance
- Normalising
- Using jargon
- Defending
- Use of questions

- **Premature advice / information:**
  HCP goes into 'giving information' mode before worries/concerns have been fully explored. Often makes HCP feel good as they like to explain/fix/come up with a solution BUT switches person into 'listening' mode, shuts down disclosure, information may be too much for person to take in (may confuse person) and may be inappropriate (ie not needed from)

MORE SUBTLE: DISTANCING BEHAVIOURS

- **Premature or false reassurance (always aim to avoid):**
  Similar to premature advice/information (may make person & HCP feel good) BUT blocks disclosure before worry/concern/problem fully explored, can block future discloser and lead to future distress (eg. falsely reassured, person may fail to realise seriousness of situation, may not engage with treatment)
- **Normalising:**
  A form of false reassurance to minimise fears and make person feel better, thereby blocking disclosure

  Patient: "I felt awful when it happened."
  HCP: *"Most people do in those circumstances, its only natural."*

  Includes 'jollying along'
  "Never mind I'm sure things will start to get better soon."

- **Using jargon:**
  Using jargon or medical terminology the person may not understand confuses person and blocks disclosure. Also, using medical terms often heard 'everyday' may lead to confusion if person's understanding not checked (and this can worsen when person uses what they have heard to others)
- **Defending:**
  Patient makes a complaint and HCP reacts at directly and doesn't explore the possible emotional content

  Patient: "I don't think I was treated very well."
  HCP: *"Well, I'm sorry you think that, we really have done the best we could for you!*
  If you want to make a complaint please go and see the Practice Manager.""

  Instead of: *"What makes you say that?"* (treating it like The Surprise Question – see below)

USE OF QUESTIONS:

- **Closed questions (ie can only answer 'yes' or 'no'):** blocks further disclosure
- **Multiple questions:**
  HCP asks a number of questions in quick succession before waiting for a response. This can confuse a person and make the response difficult to interpret (also allows person to give a response that they feel comfortable with which may allow them to avoid disclosing something important eg. pick the 'content' and avoid the 'emotion')

  HCP: *"When you saw the doctor what did he say and how did you feel?."*
  Patient: "She said they were going to be able to treat me."

- **Leading questions:**
  HCP asks in such a way that they assume the answer or 'put words into the person's mouth'

  HCP: *"That's great news isn't it?."*
  "I expect you didn't have much pain, did you?"
  "No problems with your medication?

Examples of barriers to effective communication: Person (patient/relative)

FEARS

- **of losing control / breaking down**
- **of being stigmatised** (the stigma of certain illnesses eg depression, HIV etc, or not being able to cope etc)
- **of looking foolish**
- **of worst fears being confirmed**
- **of being a burden to family OR HCP**
- **of causing distress to family OR HCP**

BELIEFS

- **HCP only concerned with certain aspects of care** (not the ones that are bothering the person)
- **HCP too busy to listen**
- **"my concerns are not as important as other people's"**
- **HCP will feel I'm complaining**
- **Person depends on HCP team so doesn't want to anger anyone and 'spoil things'**
- **I should be able to cope**
- **My family would disapprove**

SKILLS

- **Can't find the right words**
- **English is not my first language**
- **Can't read / write**
- **Don't have enough information to understand fully / clarity things**
- **Mental capacity issues**

ENVIRONMENT

- **No privacy**
- **Can't speak in front of the person with me**
- **Don't have the right person with me**

Communication skills

- Effective communication requires an awareness of the ***three components of communication***, ***picking up cues*** (and how to identify, acknowledge, check and explore them) and ***facilitation techniques***

THREE COMPONENTS OF COMMUNICATION:

- **VERBAL messages:** THE WORDS we use ....(7%)*
- **PARA-VERBAL messages:** HOW WE SAY the words ....(38%)*

WORDS SAID (bold capitals underlined words emphasised)	**POSSIBLE MEANING**
*"**I** didn't say you were an idiot"*	*"It wasn't me, it was someone else"*
*"I didn't **SAY** you were an idiot"*	*"I didn't say it, I wrote it in a letter"*
*"I didn't say **YOU** were an idiot"*	*"I called someone else an idiot"*
*"I didn't say you were an **IDIOT**"*	*"I said you were something else"*

- **NON-VERBAL messages:** BODY LANGUAGE including expressions & gestures ....(55%)*

  Body Language (The Silent Message)
  - **Personal space** (how close you get to another)
    - **Closer** more intimate/threatening; **more distant** more comfortable / detached
  - **Eye contact** (how often & how long you look at another & if gaze returned)
    - **Collects information** (getting feedback & monitoring others communication)
    - **Signals turn-taking** (needed in conversations)
    - **Conveys attitude / mood** (too much superior/threatening, too little insincere/inattentive, away & down depressed
    - **Differs in different cultures**
  - **Facial expression** (shows emotion, attitude, can show true feelings – can conflict with words said)
  - **Posture** (shows emotional response)
    - **Open:** friendly & leaning slightly forward, attentive
    - **Closed:** limbs crossed less friendly/angry/rejecting
    - **Depression:** low muscle tone, drooping head, shoulders, poor eye contact
    - **Anxiety:** increased muscle tone,
    - **Leaning: back** inattentive too relaxed; **slightly forward** friendly, attentive; **forward too much** threatening/uncomfortable
  - **Gestures** (voluntary movements eg. hands or nods of head, indicating mood, emphasizing, clarifying)
  - **Touch** (very powerful BUT cultural and personal rules about touch – can convey empathy OR assault

✱ *% according to Albert Mehrabian (1981) –important message is most communication is not verbal*

Communication skills

PICKING UP CUES "*Say what you see*":

- A cue is a hint (verbally, para-verbally or non-verbally) suggesting an underlying concern/worry/distress that needs to be clarified and explored.

Verbal & para-verbal cues include:

- words or phrases directly mentioning psychological symptoms – *"I am worried."*
- words or phrases describing psychological symptoms of unpleasant emotional states *eg. loss of libido, sleep disturbance, thoughts of self-harm* also "*the pain is overwhelming at times"*
- communication of other life-changing events – *"my mother died of breast cancer".*
- words or phrases suggesting strong but undefined emotion – *"this is killing me", "this is hard"*
- verbal hints at hidden concerns – *"not sure what I am going to do"*
- where para-verbal emphasis conveys strong emotion (annoyance, anger, sarcasm, sadness) but words or phrases are neutral / don't match emotion – *"Everything's great now."*
- Where words or phrases describe something unpleasant but said in neutral expression – *"My father died."*
- repetition of any of the above (suggesting obvious / undefined / hidden concern)
- repetition of a neutral expression – *"I don't know how I feel."*

Non-verbal cues include:

- non-verbal expression of emotion, looking away, pauses, struggling to find the words, tears, 'bouncing' knee, tapping hand,
- poor eye contact, too much contact
- hints of emotions – sighing, frowning,

Picking up on what you think is a cue does not mean you are correct;

- the next step is to check it out and in so doing, you acknowledge the cue (if you are correct)
- You may not pick up every cue, **but it is important to acknowledge** them when you do either by:

  Acknowledgement through checking / summarizing / educated guess / clarifying +/- empathy + exploration:
  "That sounded as if you it irritated you," (checking + guess)
  "*You seem quite distressed?"* (checking + guess)
  "You say you were worried and were not sleeping" (summary)
  "That sounds really difficult for you" (guess + empathy)
  "What is upsetting you?" (guess + exploration)

Once identified, explore cue further:

"What is distressing you?"
"Tell me more."

- And use other facilitation skills to explore further if needed

FACILITATION SKILLS (FS):

- These skills help the HCP to:
    - Identify key information and cues about worries/concerns
    - Acknowledge the cues, worries/concerns of the person's agenda and check the information given
    - Give simple and complex information in an effective manner tailored to person
    - Negotiate preferences, decisions and action plans

FS – for INFORMATION GATHERING:

- Question styles (Qu)
- Silences
- Minimal prompts
    - *Broad open Qu*
    - *Open directive Qu*
    - *Directive Qu*
    - *Closed Qu*
    - *Screening Qu*
    - *Clarification/exploring Qu*

QUESTION STYLES

Broad open: *"How are you?"*

- needs more than a 'Yes' / 'No' answer so encourages person to freely talk – good starting questions
- also vague, so not good for focusing

Open directive (focused): *"How are you today?"*

- needs more than a 'Yes' / 'No' answer, encourages person to freely talk – good starting questions
- less vague, focusing on person a little

Directive: *"Where is the pain?"*

- needs more than a 'Yes' / 'No' answer, requires factual answer, good for specific information gathering
- focuses person on a topic

Closed: *"Are you married?"*

- only a 'Yes' / 'No' answer, direct, specific information gathering
- so focused can limit /shut down disclosure if over used

Screening: *"Is there something else?"*

- may be interpreted as closed with 'Yes' / 'No' answer, but useful to clarify or explore int the middle and at the close of a consultation or at the very end
- *"Is there __some__thing else?"* versus *"Is there __any__thing else?"* – research shows more disclosure with *"**something**"*
- often used with summarising, it ensures no assumptions being made and everything has been said
  " Is there something else about the pain you want to add?" (end of exploring the pain)
  "To summarise, you are worried about this…and this…and this…? Is there something else?" (end of exploring the list of concerns before moving onto next consultation part)
  "To summarise, so this and this and this…is going to happen, Is there something else you want to cover before we finish?" (end of action plan before moving onto closing consultation)

Clarification / exploring:

- encourages person to clarify or say more; can be open or more directive
  Person: "I'm not feeling well." **HCP:** ***"What do you mean by that?"***
  HCP: ***"You say you cannot eat. Can you tell me exactly what happens at meal times?"***
  HCP: **"*There's this… and this… and this…,is there something else?*"** (clarifying + screening)

SILENCES (the 'Power of the Pause')

- These are very powerful **,** especially when combined with open attentive body language (sensitive maintaining of eye contact, open posture leaning slightly forward, occasional head nod minimal prompt if appropriate, other appropriate non-verbal such as passing a box of tissues if person tears up)
- Allow person to think and process thoughts / feelings and encourage further disclosure in person's time; allows HCP to think and process as well
- If pause feeling too long/uncomfortable for HCP, phrases like *"You seem deep in thought…", "Can you tell me what you are thinking about?"* can be tried

MINIMAL PROMPTS / ENCOURAGEMENT

- These are verbal phrases that encourage the person to continue speaking eg:
  "That is interesting, please go on…"

FS – for LISTENING & ACKNOWLEDGING:

- Active listening
- Facilitation/acknowledgement
- reflection
- Paraphrasing
- Summarising
- Showing empathy
- Challenging
- Educated guesses

ACTIVE LISTENING- powerful but takes practice & is exhausting over long period

- This is a skill that needs great concentration, a willingness for the HCP to abandon pre-conceived ideas about the person and what they may hear, giving their full attention to the person, picking up on and using facilitation skills to acknowledging/exploring cues and establishing the person's agenda

FACILITATION / ACKNOWLEDGEMENT

- Using small head nods & phrases such as *"yes", "Mmm", "Uh huh"* to show person is heard and taken notice of

REFLECTION – can be powerful

- Repeating the person's own words back to them to encourage them to expand, clarify.
- Often their words are used as a question or statement, stressed para-verbally and followed by a pause to encourage person to respond eg:
  "You are ***'Worried'****?" (*pause)…
  "You say he said the x-ray ***'wasn't normal'****?" (*pause)…

PARAPHRASING – can be powerful

- Similar to *Reflection,* this uses person's own words back to them BUT, it is NOT a direct quote
- **HCP reflects back their interpretation** of what has been said, using a paraphrase of person's words (so it should be said tentatively in case interpretation is wrong)
- This not only shows active listening, it adds variety and stops consultation being repetitive

SUMMARISING – can be powerful

- Summarising gives deliberate feedback to person about what you understand about what the person has told you (physical and emotional); whilst it shows actively listening it gives person opportunity to correct the HCP
- Summarising can occur in two places of the consultation:
  An internal summary – focusses on a part of the consultation eg.
  Gathering information about a symptom
  "So you say the pain is this…and this… and this.. Is there something else I should know?"
  Gathering information about the person's agenda
  "So to recap, the important things to look at today are this…and this… and this…Is there something else?

  An end summary – draws together all the parts of the consultation eg.
  "I would just like to check out that I have understood what you said correctly…this…and this…and this…" (pause)
  "And we are going to do this… and this… and this…?"

SHOWING EMPATHY – is powerful and important

- **Showing empathy** is a powerful way of:
  - Showing a person you are actively listening to them and are interested in what they think and feel
  - checking out if you have identified an cue
  - Acknowledging the cue if correct and building rapport with the person to explore further
- **Showing empathy** is a skill like any other that can be taught and is acquired with practising

Empathy vs sympathy

- **Empathy occurs** when an HCP communicates they have appreciation of the person's feelings at that time.
  - **Showing empathy:**
    - should give the person the feeling the HCP is alongside them
    - must be genuine and match the HCP's non-verbal communication
    - The HCP should only use phrases they are comfortable with eg:
      "That sounds terrible"
      "That must have been difficult for you"
      "You seem to have had a difficult time over the last few days…."
      "I cannot begin to imagine how you are feeling."

SHOWING EMPATHY

Empathy vs sympathy

- **Sympathy occurs** when the HCP communicates they have had same/similar experience.
    - **Showing sympathy:**
        a) **takes the focus away from the person and back to the HCP:**
        I know / I understand / I've had:
        "I know how you feel"
        "I had a similar experience"
        "I understand exactly how you are feeling"

        b) **takes the focus away from the person and back to other:**
        "Lots of people feel like that"
        "Other people have had similar experiences"

    NB: In palliative care it is not uncommon for patients to have seven or eight concerns that are troubling them. Most people will share the safest concerns with staff first and may not disclose the ones that are most important to them unless encouraged to do so. Picking up cues is one way that patients feel listened to and are more likely to risk sharing what is troubling them.

    NB: Two videos: used by US Cleveland Clinic to help Drs/med students to understand what empathy is and its importance to encounters with people (also see videos on the *SPIKEs strategy for breaking bad news* where E is empathy – page 22)

    Cleveland Clinic's Empathy Series: --Empathy: The Human Connection to Patient Care
    https://youtu.be/cDDWvj_q-o8

    Cleveland Clinic's Empathy Series -- Patients: Afraid and Vulnerable
    https://youtu.be/1e1JxPCDme4

CHALLENGING

- Questions that challenge any inconsistencies HPC sees in what person said eg:
  "You said you manage at home because you have no family and don't want carers, and yet you want to go home as soon as possible. Can we discuss this further?"

  "You said you are feeling great, but then said you are quite anxious. Can you tell me a bit more about this?"

EDUCATED GUESSES – can be powerful

- It is a mixture of a suggestion (possibly with empathy and paraphrasing), usually put tentatively to allow person to correct if wrong, that shows person the HCP is interested and listening and trying to understand what person is experiencing. Eg.
  "It sounds like things have been really hard for you recently. Is that correct?

FS – for INFORMATION GIVING & NEGOTIATING DECISIONS:

- checking understanding
- overviewing & navigating
- "chunking & checking"
- Using pauses
- keeping language & detail simple

CHECK UNDERSTANDING

- Find out what person knows from very start using open questions then clarify and check and acknowledge what is said
  "What did the doctor in the hospital tell you exactly?"
  "Can you tell me why you have come today?"
  "You say you have arthritis, tell me what you understand about that?

OVERVIEWING & NAVIGATING

- Where situations are complex it helps to give the person a clear idea of how the HCP will give information and helps the person to see how things 'fit together'
  "There is a lot to go through today, so I thought it may be helpful to break it into sections. Is that OK?"
  "Firstly I would like us to talk about what your illness is; then I would like to move onto how we can help you medically and lastly we can discuss the things you can do to help yourself. Are you alright with that?"

"CHUNKING & CHECKING"

- Where there is a lot of information, it is vital to break it into small 'chunks' of information to deliver (delivering chunks that are too large may mean person cannot assimilate or remember things
- Deliver a 'chunk' and PAUSE, then CHECK it is OK to go on; you must always periodically CHECK the person's understanding of what they have heard and with some information (eg. serious diagnosis) you may have to check this after each 'chunk'
- The SPIKES strategy of delivering significant news (including bad news) uses this

USE PAUSES

- These are vital when giving information to allow person to 'digest' information
- When judging how long to pause for, watch the person's non-verbal communication; people may look away whilst thinking, then resume eye contact when ready to carry on; verbal cues may be explicit *("What happens after this?"*) but sometimes they are non-specific (eg *"Uhhuh", "Mmm", "Ok, then")* and need clarifying **"Can you tell me what you are thinking?"* or *"What do you mean by that?"*)
- If you are unsure if you can move on, check with person (*"Do you understand what I just said?", "Is it OK for me to go on?"*)

KEEP LANGUAGE CLEAR & SIMPLE

- Using the medical terms and abbreviations that HPCs are familiar with can lead to confusion with people who are unfamiliar with them; Care should even be taking with patients/relative who are HPCs, don't assume they understand – so avoid jargon and medical terms unless needed (and then carefully explain what you are using the term to mean
- *The amount of information a person needs to hear is the amount that they need at that time, NOT the amount the HPC feels they need to know*; when breaking bad news a person may not get beyond receiving the bad news itself and will not be able to process the details of what the HPC wants to discuss; *"Chunking & Checking*" then *Pausing* then asking if it *is OK to move on* will allow person to tell the HPC they have had enough for that consultation. The HPC must then negotiate a way where the conversation can be resumed if it is what the person wants. In this way, the HCP can tailor the information to the person's needs at the time. If it is not possible to give all the information the HCP feels person needs to know, the HCP can negotiate with person when this can be done in future as part of forming the management plan.

CHECK UNDERSTANDING

- This should be done during the information giving process and at the end negotiating further management plan
- Try to get the person to tell you in their own words what they understand (using a closed question such as *"Do you understand?"* or *"Does that make sense?"* may produce a "Yes" answer when the person has not fully understood.
- Check understanding either directly, eg *"Can you tell me what you have understood from what I have just said?"* or indirectly listening to the person's questions *"Will I always feel dizzy on this medication because my blood pressure keeps falling?"* (ie person has understood the medication has caused low BP which in turn is making them dizzy)

Effective communication

The consultation

- Three aspects are affect how effective a consultation is:

Consultation Context:

- Affects appropriateness, HCP's approach & use of HCP skills, including:
    - **The Setting:** (eg. acute, chronic, emergency –determines focus and main objective of consultation)
    - **Previous relationship:** (has HCP met person before, if so they may have way of communicating)
    - **Previous knowledge:** (if HCP knows person, what has been discussed before & what is understood?)

Consultation Skills:

- Key interviewing skills needed including:

– Eliciting key information & picking up cues – Acknowledging & checking this information	(**'Gathering / Exploring'** skills)
– Giving information	(**'Giving / Explaining'** skills)
– Negotiating preferences & actions	(**'Decision making'** skills)

NB: Important to always:
"Gather before you **Give**" OR "**Explore** before you **Explain**"

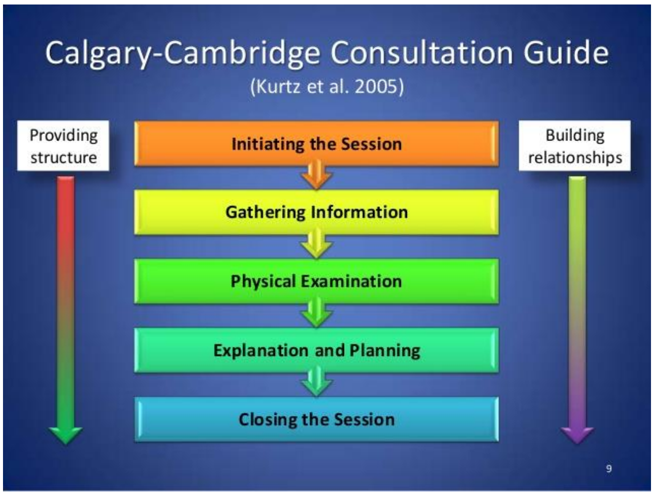
Consultation Structure:

- Having a clear, **cue based structure** to move through during a consultation eg:
    - **Calgary-Cambridge Consultation** Model (Liverpool University uses this -see below)
    - **SAGE and THYME Model** For Identifying Concerns and Managing Expectations (see below)
- Having a clear approaches to handle difficult types of conversation eg:
    - **SPIKES** strategy for breaking significant news (eg. bad news)
    - Strategy for dealing with strong emotion eg anger
    - Strategy for dealing with collusion
    - Strategy for dealing with denial
    - Strategy for dealing with a 'surprise question'

Consultation Models

Calgary – Cambridge (see below)

- Liverpool Medical School base their approach to teaching communication skills training on the Calgary-Cambridge Consultation model (there are other consultation models particularly in General Practice).
- For each stage of the model there are key communication skills that need to be used (*Initiation, Gathering Information, Physical Examination, Explanation & Planning, Closing Session)*. Some may be very familiar, such as introducing yourself, ensuring the identity of the patient and putting them at ease. However, there may be a time in clinical practice when the approach has to be adapted from your routine practice or where what you "normally do" does not work … being able to communicate well means being able to adapt your style and approach when needed.



Calgary-Cambridge Consultation Guide

(Kurtz et al. 2005)

Providing structure

Initiating the Session

Gathering Information

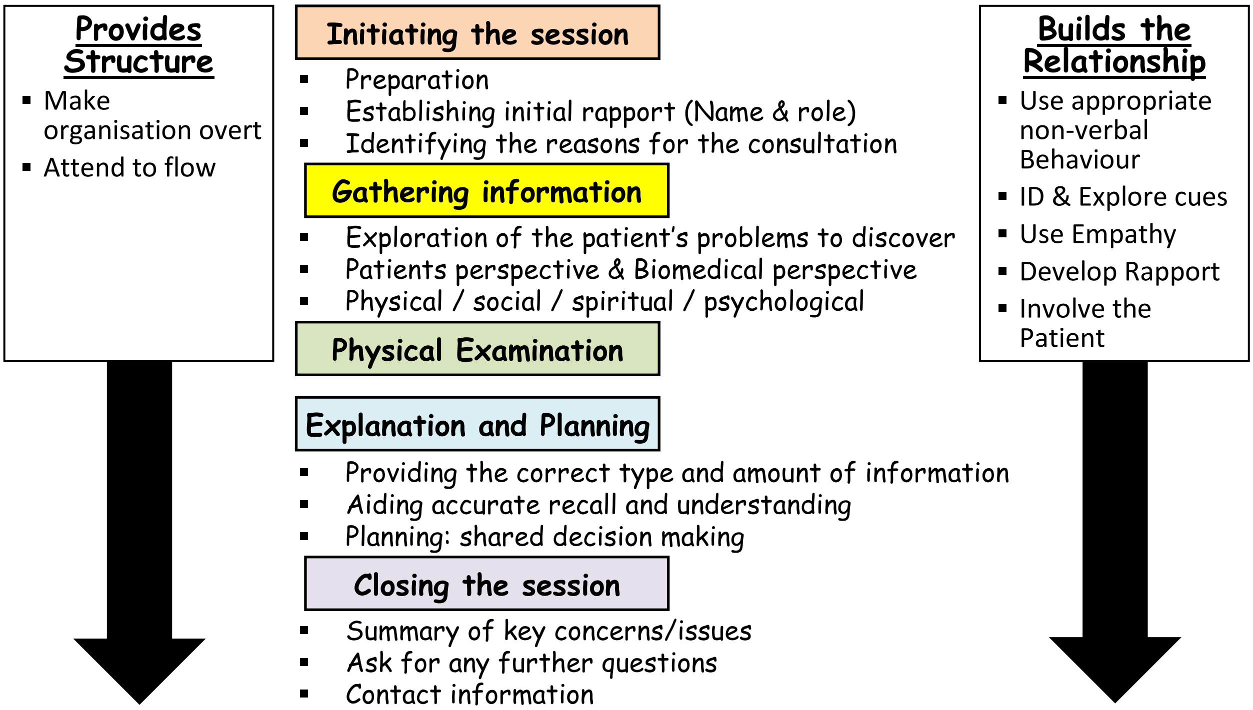
Physical Examination

Explanation and Planning

Closing the Session

Building relationships

9



Provides Structure

- Make organisation overt
- Attend to flow

Initiating the session

- Preparation
- Establishing initial rapport (Name & role)
- Identifying the reasons for the consultation

Gathering information

- Exploration of the patient’s problems to discover
- Patients perspective & Biomedical perspective
- Physical / social / spiritual / psychological

Physical Examination

Explanation and Planning

- Providing the correct type and amount of information
- Aiding accurate recall and understanding
- Planning: shared decision making

Closing the session

- Summary of key concerns/issues
- Ask for any further questions
- Contact information

Builds the Relationship

- Use appropriate non-verbal Behaviour
- ID & Explore cues
- Use Empathy
- Develop Rapport
- Involve the Patient

SAGE and THYME Model For Identifying Concerns and Managing Expectations

- It can also help to use a framework such as SAGE and THYME. This model does not offer any fixes rather empowers the patient voice their concerns and then identify for themselves how best to manage the concerns they have.

Setting: is this the right place and the right time?

Ask: how can I help?

Gather: what else?

Empathy: show this

Talk: have you anyone to talk to / have you talked?

Help: has talking been helpful or would it be helpful?

You: what do ***you*** think might help?

Me: what would you like ***me*** to do?

End: summary and act on what was agreed

- Sharing concerns can help patients make informed decisions about their care, where there may be little certainty about their management and where there are few actual or possible fixes for their underlying condition.

Guidance for particular situations

Handling Difficult Conversations

No one likes to have a difficult conversation – we have all developed skills to avoid them and reduce the impact of them on ourselves when we do have them.

However, as doctors, we will be involved in a large number of difficult conversations with people including:

- telling a patient they have cancer;
- telling a patient or a relative that they, or a loved one, will not get better, are not responding to the treatment as hoped, are dying;
- discussing ceilings of treatment including Do Not Attempt Cardio-Pulmonary Resuscitation orders;
- managing uncertainty around diagnosis or treatment plan;
- managing strong emotion;
- managing unrealistic expectations;
- managing patients or relatives who want you to do something that you do not want to do or cannot do because it is not line with good medical practice or is illegal;
- being asked to not tell the truth.

Potential barriers to effective communication for "difficult conversations" such as breaking bad news, dealing with psychological issues, managing uncertainty etc include those on Page 7

Having a difficult conversation can be as hard for us as doctors as it is for the patients and so we can block patients from disclosing what they are thinking or feeling (see page 8).

- Complete change of topic.
- Distancing strategies
    - removal of emotion
    - change of time frame
    - change of person usually from the individual to generalities.

- Premature reassurance/advice/information.
- Normalising.
- Minimising.

We can also inhibit disclosure by:

- only asking questions about physical issues
- offering inappropriate information or so much information the patient is overwhelmed
- only asking closed questions
- asking multiple questions in one sentence
- leading questions
- passing the buck
- defending
- jollying along
- chit chat

There are a number of facilitative skills which can be used within a difficult conversation that enable the doctor to:

- identify patient's agenda/concerns (not what you as a doctor assume they might be);
- acknowledge patient's agenda/concerns (even if they are not the ones you thought they might be);
- negotiate decision making (increasing the likelihood of compliance and improved outcomes);
- give tailored information effectively (avoiding jargon, splitting the information up into more manageable bite sizes, delivered in a sequential manner over time).

Facilitative skills (see pages 13-16) include:

- open questions
- open directive questions
- showing appropriate empathy
- summarising
- educated guesses
- picking up cues
- acknowledging/reflection/paraphrasing
- checking
- clarifying
- exploring.

Effective Communication Skills When Engaging In Difficult and/or Complex Conversations

Many difficult conversations involve situations where there is no "fix" and/or contain bad news.

- Bad news can never be made into good news.
- Most people will have sufficient resilience and coping strategies to handle the "bad news" once they have recovered from the initial shock.

Patients will only retain around 10% of the information given to them in a consultation where significant news is broken, so do not give any more information than the patient asks for or is essential for that moment.

Skills That Help When Giving Significant Information/Breaking Bad News:

- Engage with the psychological such as thoughts, feelings and fears.
- Active listening (not simply waiting to ask your next question).
- Pauses and not invading the silence.
- Minimal prompts – encouraging the patient to take the lead.
- Appropriate information.
- Tailored information (chunking & checking).
- Appropriate and realistic reassurance – but not promising what is not in our gift.
- Screening.
- Jargon free.

Strategies That Help When Giving Significant Information/Breaking Bad News (see below):

- SPIKES Plus
- ABCDE

Exploring feelings -The following techniques may assist:

- **Recognition:** just seeing the verbal / non-verbal evidence
- **Acknowledgement:** *"I can see you are upset"*
- **Understanding:** *"Help me to understand what is making you sad.", *I want to understand…"*
- **Permission***: "You have every right to be angry." "It's OK to be anxious."*
- **Empathetic acceptance:** *"You are upset because what you've been through sounds dreadful."*
- **Assessment*:*** *assess the severity and effects of the feelings*

The Surprise Question Strategy

That May Help when people ask difficult questions such as: *"Am I dying?" "Have I got cancer?"*

Key points:

- Don't answer the question directly, find out person's reason to ask
  "What makes you ask that?" "What makes you think that?"
- After the reply, consider if there other reasons for asking / feeling this way
- If person doesn't give a reason / changes the subject consider going back to the question
  "You asked about dying, is that something you want to talk about?"
- If person says no – stop as person may not be ready to discuss – otherwise proceed as below
- Pause to see if person raises concerns spontaneously; if none raised, invite person to voice their concerns
- Only address the concerns raised; answer truthfully and realistically avoiding premature or false reassurance
- Invite further questions and deal with as above
- Offer to provide information if relevant
- Don't forget about continuity of care afterwards (communicating with relevant others if needed, arranging follow up as appropriate

Communicating Significant News/Breaking Bad News

The communication of significant (bad) news is not a one off event, rather a process which starts as soon as a patient seeks help. Good communication of significant news is a two way process based on what a patient already knows or thinks they know and how much they want to know, delivered by a competent and caring professional at a pace suited to them.

General

- Significant/bad news is **always** bad news, do not try and make it into good news.
- Significant/bad news is what the patient perceives it to be (you may not think it is all that bad!).
- Be clear, empathic and jargon free.
- Ensure that you use the words needed such as cancer or dying – avoid euphemisms.
- Do not make promises you cannot keep.
- Do not make promises on behalf of colleagues that cannot be met by them.

- Record clearly in notes the encounter:
  - date and time
  - all who were present
  - clear summary of what was said including the words used to break bad news
  - summary of patient's response – appeared shocked, resigned, angry etc
  - summary of relative's response
  - the plan outlined and next steps.

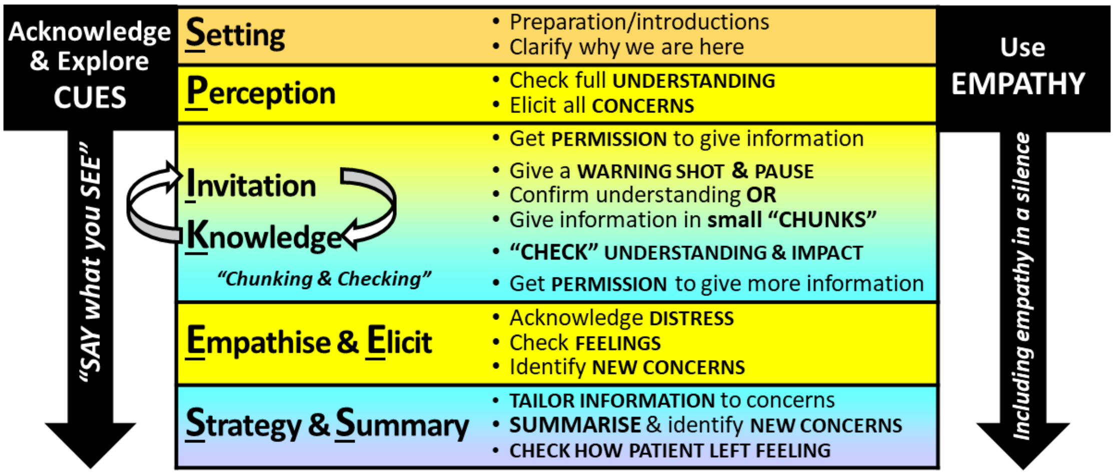
- Make sure you communicate clearly with other team members especially if other tasks need to be completed such as referral onwards or further tests. Look after yourself – breaking bad news is emotionally draining – you may need to have a quiet few minutes before moving onto your next task.

SPIKES Plus Strategy (see below)

NB: NHS Video: teaching SPIKES to hospital clinicians
SPIKES - Communicating Difficult News - End of Life Care
https://youtu.be/tddwnIVpgwc

- This model allows the person's understanding, concerns & feelings to be acknowledged from the start
- Allows information to be delivered in manageable chunks and tailors to the persons needs
- Shows the importance of giving a *warning shot* before giving bad news
- Shows the importance of using cues throughout the process
- Shows the importance of using empathy throughout
- Ideally the person should have a trusted friend/family member present for support

SPIKES 'Plus' – ***model for breaking bad news/giving significant info***



Setting	• Preparation/introductions • Clarify why we are here
Perception	• Check full **UNDERSTANDING** • Elicit all **CONCERNS**
Invitation Knowledge *"Chunking & Checking"*	• Get **PERMISSION** to give information • Give a **WARNING SHOT & PAUSE** • Confirm understanding **OR** • Give information in **small "CHUNKS"** • **"CHECK" UNDERSTANDING & IMPACT** • Get **PERMISSION** to give more information
Empathise & Elicit	• Acknowledge **DISTRESS** • Check **FEELINGS** • Identify **NEW CONCERNS**
Strategy & Summary	• **TAILOR INFORMATION** to concerns • **SUMMARISE** & identify **NEW CONCERNS** • **CHECK HOW PATIENT LEFT FEELING**

Another approach to breaking significant/bad news – A B C D E

Advanced preparation

- arrange adequate time and privacy
- confirm medical facts
- review clinical data and make sure you are comfortable with it
- emotionally prepare for the encounter (plan for appropriate scenarios).

Building a therapeutic relationship

- identify patient preferences regarding disclosure of bad news.

Communicate as well as you can

- determine the patient’s knowledge and understanding
- proceed at patient’s pace
- avoid medical jargon or euphemisms
- allow for silence
- allow tears
- answer questions honestly.

Deal with patient and relatives reaction

- assess and respond to emotional reactions
- show empathy.

Encourage and validate emotions

- offer realistic hope based on patients goals
- acknowledge the seriousness and emotional impact of the situation
- deal with own needs.

Preparation BEFORE patient arrives - vital

(S in SPIKES, A in ABCD, First Stage of Calgary-Cambridge Model)

Includes:

- Read patient records:
    - Clinical history, diagnostic and test information
    - Social aspects – including systems of support (ideally, if present, look at genogram for the most significant people) job, dependants
    - Any other background history (medical, mental health etc)
- Check:
    - You are the right person to do this (including emotionally)
    - You have privacy
    - Other aspects of room are ok re. comfort etc
    - Will be no interruptions
    - Tissues, water to drink available if needed
    - You have time to carry out task
- Plan (ideally):
    - what you want to achieve
    - what you want to avoid
    - information leaflets / other support to hand

Advance Care Planning (ACP)

NB: Gold Standards Framework Video: What is ACP? https://youtu.be/i2k6U6inIjQ

Dying Matters Video: on the importance of ACP *"I didn't want that" – warning may upset* https://www.youtube.com/watch?v=bYy4q8R9kro&feature=youtu.be

The incorporation of Advance Care Planning into end of life care means that we are all facing the challenge of having difficult conversations with patients about issues such as Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR), and ceilings of treatment. The following guidance may help to open discussions, lead to open and honest conversations, and result in greater likelihood of achieving the patient's wishes and following GMC guidance.

If you find opening discussions about end of life difficult, the following conversation openers might help:
"What are your thoughts about the future? How do you see things going?"
"In thinking about the future, have you thought about where you would prefer to be cared for as your illness gets worse?"
"What do you see happening with your illness over the next few months?"
"It would be good to discuss what kind of medical care you would want if you should get sick again. How do you feel about talking about this?"

Introducing a conversation about resuscitation may lead on from discussions about prognosis and the patient going on a GP palliative care register, or discussing the patient's understanding of the course of their illness. It may however require the professional to ask **open direct questions** in order to raise the issue specifically.
"You said you haven't been feeling as well the last few weeks, what is your understanding of what is happening?"

Within the conversation look for cues from the patient, on which you can pick up to steer the conversation in the direction you need it to go.
"You said earlier that you feel things are getting worse, shall we (can we) talk more about that?"
"You said you are anxious about the future, would it help to discuss what kind of things can be put into place to make sure your choices are upheld?"
"You said you are finding things very hard, is it ok if I ask you more about that?"
"You said you don't want to go back into hospital, would it help to write down your priorities in an advance care plan?"

Patients Who Don't Give Specific Cues

Within your consultation ask the patient specifically about their view of the future
"In thinking about the future, have you thought about where you would prefer to be cared for as your illness gets worse?"
"It would be good to discuss what kind of medical care you would want if you should get sick again.

When you need to raise the subject specifically:
"It is important that we put things in place to keep you safe, I wonder if I could talk to you about that?"
"Can we discuss some important issues around your care in the future?
In light of all the things that have been happening to you recently it is important we talk about what you feel about issues such as resuscitation (be ready to explain what you mean by resuscitation)
If they respond with "No", you would need to follow-up with another direct "It is important that we make sure things are in place to help you and those looking after you" .

When talking about patient priorities for future care, use the skills of empathy and acknowledgement explicitly,
"You are obviously concerned about how things may go in the future?
What would help you to feel more confident about the future?"
"You said your health worries you, what is it that is most worrying?"
"You don't think your husband would be able to manage, although you would like to stay at home?
"That must be hard for you?"

Use clarification to check their understanding:
"Can you explain to me what you understand about your condition?"
"Can you tell me what you feel may happen in the future?"

Do Not Attempt Cardio-Pulmonary Resuscitation" (DNACPR) Discussions

(see current guidance below)

This process should be seen as similar to breaking bad news as it is related to a poor prognosis – and needs to follow a similar framework including the same kind of care in setting up the conversation and giving it sufficient time. It is a difficult conversation because there is a lot of misunderstanding about both the success of CPR and what it actually is. In addition it is harder to tell people what you are not going to do rather than what you are going to do. In addition there can be a conflict between professional assessment of a patient and the patient's expectations of what the professional should be doing.

- Highlight to the person that the conversation is going to be about how things are going in terms of their illness.
- Assess the person's understanding of the current situation and check if that understanding is realistic and fits with the view of the current caring team.

If the patient is unrealistic or appears to have little understanding of their current situation

- Treat the conversation as a breaking bad news/giving significant information scenario around prognosis and proceed that way with firing a warning shot etc.

If the person is aware that death is imminent/likely

- Confirm their understanding using empathy.
- Explain that in light of that fact if their heart were to stop the team would not try to restart it.
- Wait for reaction – allow time – check understanding.
- Check/acknowledge patient's feelings.
- Deal with new concerns or unanswered questions.
- Do not offer false reassurance or unrealistic hope (we might be able to ... if you were to ...)

If the person is aware that things are not going well/prognosis is poor but not aware of the likelihood of death

- Introduce the topic using a warning shot: *"sadly your illness has got to a point where carrying out certain procedures may cause more harm than good" (wait) – "this includes things like trying to restart your heart if it were to stop"*
  Or
  Sadly there is the chance that being so poorly you might get even sicker than you are now quite quickly (wait) – "this may result in your heart stopping".

- Pause and allow the warning shot to sink in before continuing: *"This means that trying to restart your heart using Cardio-Pulmonary Resuscitation (CPR) is very unlikely to work for you"*
  Or
  "If this does happen it may not be possible to restart your heart – this is what we call resuscitation".

- Pause and allow the warning shot and explanation to sink in before continuing, picking up the cues offered by the person and clarifying issues they raise.

- Check understanding: *"Can I check with you what you understand about what we have just talked about?"*

- Be clear this is just about restarting the heart – not about any other type of medical care including pain relief, giving food and fluids, use of antibiotics etc.

- Check and/or acknowledge the person's feelings.

- Check for new concerns or unanswered questions.

- Check if there is a need to talk to other members of the family or those close to the patient.

- Summarise and close.

Current Guidance on DNACPR decisions

Decisions relating to Cardiopulmonary Resuscitation (3rd edition - 1st revision) – link to guidance: https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

Main Points

The main messages below are not designed to be read in isolation from the rest of the document. Given the very serious nature of the decisions being made, readers are urged to take the time to consider the whole document.

These 'messages' are intended as an aide-mémoire to highlight some of the main points arising from the guidance.

1. Considering explicitly, and whenever possible making specific anticipatory decisions about, whether or not to attempt CPR is an important part of good-quality

care for any person who is approaching the end of life and/or is at risk of cardiorespiratory arrest.

2. If cardiorespiratory arrest is not predicted or reasonably foreseeable in the current circumstances or treatment episode, it is not necessary to initiate discussion about CPR with patients.

3. For many people, anticipatory decisions about CPR are best made in the wider context of advance care planning, before a crisis necessitates a hurried decision in an emergency setting.

4. Every decision about CPR must be made on the basis of a careful assessment of each individual's situation. These decisions should never be dictated by 'blanket' policies.

5. Each decision about CPR should be subject to review based on the person's individual circumstances. In the setting of an acute illness, review should be sufficiently frequent to allow a change of decision (in either direction) in response to the person's clinical progress or lack thereof. In the setting of end-of-life care for a progressive, irreversible condition there may be little or no need for review of the decision.

6. Triggers for review should include any request from the patient or those close to them, any substantial change in the patient's clinical condition or prognosis and transfer of the patient to a different location(including transfer within a healthcare establishment).

7. For a person in whom CPR may be successful, when a decision about future CPR is being considered there must be a presumption in favour of involvement of the person in the decision-making process. If she or he lacks capacity those close to them must be involved in discussions to explore the person's wishes, feelings, beliefs and values in order to reach a 'best interests' decision. It is important to ensure that they understand that (in the absence of an applicable power of attorney or court-appointed deputy or guardian) they are not the final decision-makers, but they have an important role in helping the healthcare team to make a decision that is in the patient's best interests.

8. If a patient with capacity refuses CPR, or a patient lacking capacity has a valid and applicable advance decision to refuse treatment (ADRT), specifically refusing CPR, this must be respected.

9. If the healthcare team is as certain as it can be that a person is dying as an inevitable result of underlying disease or a catastrophic health event, and CPR would not re-start the heart and breathing for a sustained period, CPR should not be attempted.

10. Even when CPR has no realistic prospect of success, there must be a presumption in favour of explaining the need and basis for a DNACPR decision to a patient, or to those close to a patient who lacks capacity. It is not necessary to obtain the consent of a patient or of those close to a patient to a decision not to attempt CPR that has no realistic prospect of success. The patient and those close to the patient do not have a right to demand treatment that is clinically inappropriate and healthcare professionals have no obligation to offer or deliver such treatment.

11. Where there is a clear clinical need for a DNACPR decision in a dying patient for whom CPR offers no realistic prospect of success, that decision should be made and explained to the patient and those close to the patient at the earliest practicable and appropriate opportunity.

12. Where a patient or those close to a patient disagree with a DNACPR decision a second opinion should be offered. Endorsement of a DNACPR decision by all members of a multidisciplinary team may avoid the need to offer a further opinion.

13. Effective communication is essential to ensure that decisions about CPR are made well and understood clearly by all those involved. There should be clear, accurate, honest and timely communication with the patient and (unless the patient has requested confidentiality) those close to the patient, including provision of information and checking their understanding of what has been explained to them. Agreeing broader goals of care with patients and those close to patients is an essential prerequisite to enabling each of them to understand decisions about CPR in context.

14. Unnecessary delay in offering discussions, explanations and information about CPR decisions can lead to misunderstanding and dissatisfaction. Delivering these communications in an inappropriate or insensitive way can also lead to dissatisfaction. A decision to delay or avoid communication of a decision to a patient must be based on that communication being likely to cause the patient physical or psychological harm. A decision to delay communication of a decision to those close to a patient without capacity must be based on that communication being either not practicable or not appropriate in the circumstances.

15. Any decision about CPR should be communicated clearly to all those involved in the patient's care.

16. It is essential that healthcare professionals, patients and those close to patients understand that a decision not to attempt CPR applies only to CPR and not to any other element of care or treatment. A DNACPR decision must not be allowed to compromise high quality delivery of any other aspect of care.

17. A DNACPR decision does not override clinical judgement in the unlikely event of a reversible cause of the person's respiratory or cardiac arrest that does not match the circumstances envisaged when that decision was made and recorded. Examples of such reversible causes include but are not restricted to – choking, a displaced tracheal tube or a blocked tracheostomy tube.

18. Decisions about CPR must be free from any discrimination, for example in respect of a disability. A best-interests decision about CPR is unique to each person and is to be guided by the quality of future life that the person themselves would regard as acceptable or, in the case of children taken into account the views of the child and parents.

19. Clear and full documentation of decisions about CPR, the reasons for them, and the discussions that informed those decisions, is an essential part of high-quality care. This often requires documentation in the health record of detail beyond the content of a specific CPR decision form. Where such discussions are not practicable or not appropriate, the reasons for this must be documented fully.

20. A CPR decision form in itself is not legally binding. The form should be regarded as an advance clinical assessment and decision, recorded to guide immediate clinical decision-making in the event of a patient's cardiorespiratory arrest or death. The final decision regarding whether or not attempting CPR is clinically appropriate and lawful rests with the healthcare professionals responsible for the patient's immediate care at that time.

21. Use of a CPR decision form that is used, recognised and accepted across geographical and organisational boundaries is a basic recommendation and may be paper-based or electronic, subject to local agreement.

22. Recorded decisions about CPR should accompany a patient when they move from one setting to another.

23. Records of decisions about CPR must be accurate and up-to-date. Systems (whether paper-based or electronic) for recording these decisions must be reliable and responsive, in particular, to any change in the decision about CPR.

24. Where no explicit decision about CPR has been considered and recorded in advance there should be an initial presumption in favour of CPR. However, in some circumstances where there is no recorded explicit decision (for example for a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful) a carefully considered decision not to start inappropriate CPR should be supported.

25. Failure to make timely and appropriate decisions about CPR will leave people at risk of receiving inappropriate or unwanted attempts at CPR as they die. The resulting indignity, with no prospect of benefit, is unacceptable, especially when many would not have wanted CPR had their needs and wishes been explored.

Strong Emotions/Handling Anger

NB: US Dr Video: On how to manage anger – very American / OTT / funny but principles there
The Universal Upset Patient Protocol
https://youtu.be/C1YsNGupQhI

Handling strong emotions is challenging. Anger in particular is a complex emotion and hard to handle because its expression often feels like a personal attack on you and your practice.

It is essential that you make an assessment of a situation and if you think there is a possibility that anger or other strong emotion will escalate and put you in danger you should not start a consultation on your own or, if you do, ensure you can raise the alarm and escape if needed.

It is important to encourage the verbal expression of anger and strong emotion.

Ventilation of the strong emotion (in people with a normal mental state) will enable a more rational exploration of the causes for that strong emotion, once the strong emotion has burnt itself out which it will do if allowed to do so without interruption.

The following can be helpful:

- **Acknowledge the strong emotion** ***being careful not to minimise it or change the intensity***

  You sound very angry
  You seem very upset.

- **Ask about the strong emotion** – invite the person to tell you why they are feeling so strongly

  Could you tell me what is making you angry/upset?

- **Do not respond to the reasons given** – ***acknowledge them in a non-judgemental and non-defensive manner***. Use empathy if appropriate

  I can see you are really angry about … it must be difficult having to wait …

- **Do not assume there is only one reason for the strong emotion**. ***Encourage the person to give all their reasons***

  Before I explain can I just check if there is anything else about the situation that is making you angry/upset?

- **As the person talks about the reasons for their strong emotion look for "transition"** – ***a time when the strong emotion subsides and other feelings become prominent - sadness, loss, guilt – explore these as appropriate.***

- **Summarise back in a non-judgemental and non-defensive manner the issues shared**

  Can I just check that I have got the issues you are angry about …

- **Invite the patient to suggest what next steps would help and if appropriate offer an apology and appropriate empathy**

  Have you had any thoughts about what would help to address the concerns that have made you angry?

Working With Collusion – Promoting Openness

Collusion (hiding information from individuals) creates problems for both the colluder and the person being colluded against. Eg. when relative puts permission on HCP not to disclosed *"Don't tell him Dr, he will give up."*

Key Points of focus:

- The relatives feelings
- The relatives reasons for not wanting the truth
- Acknowledging the relatives motives (eg protecting their loved one)
- The strain placed on relative's relationship by not being truthful
- The relative's perception of the patient's understanding
    - see if there is evidence the patient may already know
    - offer to assess the patient's understanding
- reassuring the relative any information will not be forced onto relative

Stage 1 - Talking to the person responsible for the collusion

Understand the reasons

- Explore why the colluder believes collusion is in their relatives best interest and establish how strong these beliefs are.
- Accept that these reasons are legitimate.

Eliciting the cost

- Ask how they are managing day to day with the situation.
- Be alert to cues about emotional strain that they may be experiencing as a result of the collusion and explore them.
- Check if the collusion is having any effect on the relationship with the individual (there usually is some effect).

Presenting the contract

- Summarise the costs to the colluder and ask them if they are willing to consider letting you talk to their relative to check their understanding.
- Acknowledge the ambivalence the colluder is feeling.
- Present the duty of confidentiality an HCPs has to their patient
- Negotiate to tell the patient only what the patient wants to know about and no more.

Stage 2 - Talking to the patient

- Check the patient's view of the situation and what they understand and interpret about what has happened so far.
- Check how the patient has been left feeling by what has happened.
- Find out why the patient has not asked questions of the colluder and what they think the colluder knows about the situation.
- Check if they want to know more and if they would be comfortable to meet with you and their partner to do this.

Stage 3 - Seeing the couple together

- Recap the situation, pause and acknowledge their distress.
- Give space for strong emotion.
- Check both parties are willing to talk.
- Follow the breaking significant news process.

If they agree to talk things through encourage both parties to identify their concerns.
Screen for other concerns and encourage the couple to think about positive goals they work together to achieve.

Dealing With "Denial"

Denial is when a person maintains a positive outlook on their situation in spite of receiving medical information to the contrary – it is a coping mechanism.

The function of denial is to protect the patient from something which would cause intolerable pain and distress. It is not our job to prevent patients coping in this way but to ***tentatively explore underlying concerns to see if they can be addressed or help those for whom denial is no longer complete or working as a coping mechanism.***

If denial is absolute (which is extremely rare) – then the patient needs very careful management by senior clinicians and you should draw the consultation to a close as constructively as you can and explain you are referring this on to another doctor. Forcing through the denial can lead to severe psychological problems.

Key to explore:

- Look for evidence that denial is not absolute (ie. a 'window' to work with)
    - PRESENT: *"How do you feel things are going at the moment?"*
    - PAST: *"Was there ever a point in the past when you thought things were not going to work out?"*
    - FUTURE: *"How do you see you illness affecting your future."*
    - A window could be an inconsistency in what is said, try to gently challenge
      "You said you don't have anything serious,
      but didn't you also tell me you had an intensive course of chemotherapy?"
- If person accepts things are not right, gently explore
    - *"Can you bear to talk about it?"*
- If person does open up a little,
    - actively listen
    - acknowledge & try to explore their feelings and concerns (using a lot of empathy)
    - get permission to address only the concerns raised
- be aware that specialist help may be needed & ensure there is regular follow up regardless of outcome

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